

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026627

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

317

Primary Registration District No.

590

Registrar's No.

1962

STATE FILE NUMBER

DO NOT WRITE  
ON THIS SUB

AMENDED

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

FILED JUL 1 1963

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jefferson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Valley Park</b>		Length of stay in lb <b>9 Days</b>	c. CITY OR TOWN <b>Fenton</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Valley Park Nursing Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>#12 Circle Drive</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LENA</b> Middle <b>*****</b> Last <b>FLEISS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>1963</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/11/190</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	9. AGE (last birthday) <b>72 yrs.</b>
11a. FATHER'S NAME <b>John Angermann</b>		11b. MOTHER'S MAIDEN NAME <b>Emma Unseld</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>John Angermann</b>		14. NAME OF HUSBAND OR WIFE <b>the Rev. George A. Fleiss</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		17. INFORMANT Address <b>Mr. Norman R. Fleiss, 1200 Darding Dr. (25)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cystadenoma of both ovaries</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from <b>June 7, 1963</b> to <b>June 16, 1963</b> and last saw her alive on <b>June 13, 1963</b> Death occurred at <b>2:15 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Robert D. Sanders, M.D.</b> (Degree or title)		22b. ADDRESS <b>5500 S Broadway</b>	22c. DATE SIGNED <b>6-17-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>June 19, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Walnut Grove Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Boonville, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Beiderwieden F.H. Inc., 1936 St. Louis (6)</b>		25. DATE RECD. BY LOCAL REG. <b>6-18-63</b>	26. REGISTRAR'S SIGNATURE <b>John B. Muench, M.D.</b>

Dr. Robert D. Landwehr  
at Elginville Nursing  
Home  
5500 So. Broadway  
2-4 30 pm.

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*David J. Seal*

Licensed Embalmer No.

*4520*

P. O. Address

*St Louis, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.